INTRODUCTION

WHO Resolution

Between 1970 and 1995, WHO adopted 14 resolutions on the need for both national and international tobacco control policies. Four of the 14 resolutions are relevant to the UNF-project—GYTS survey. Member states were encouraged to implement comprehensive tobacco control strategies that contain the following:

1. Measures to ensure that non-smokers receive effective protection, to which they are entitled, from involuntary exposure to tobacco smoke.
2. Measures to promote abstention from the use of tobacco so as to protect children and young people from becoming addicted.
3. The establishment of programmes of education and public information on tobacco and health issues, including smoking cessation programmes, with active involvement of the health professionals and the media.
4. Monitoring of trends in smoking and other forms of tobacco use, tobacco-related disease, and effectiveness of national smoking control action.

Public Health Impact

Despite widespread knowledge of the harm caused by smoking, only modest success has been achieved in global tobacco control initiatives. WHO estimates that there are currently 3.5 million deaths a year from tobacco, a figure expected to rise about 10million by 2030. By that date, 70% of those deaths will occur in developing countries.

Tobacco use is considered to be one chief preventable cause of death in the world. WHO is concerned about the decreasing age of smoking initiation. Data revealed that in many countries, the median age of smoking initiation was under the age of 15. This is of particular concern, since starting to smoke at younger ages increases the risk of death from a smoking-related cause. Among those who continue to smoke throughout their lives, about half can be expected to die from a smoking-related cause, with half of those deaths occurring in middle age. Therefore, adolescents and school-aged children should be a primary focus for intervention strategies. Carefully designed strategies should provide a clear picture of the risk factor behaviors of young and school-aged children which then can be used to set up more effective and comprehensive tobacco control policies.

Tobacco Use in Zimbabwe

Tobacco is the main foreign currency earner in Zimbabwe, accounting for 33% of Zimbabwe's agricultural earnings and 30% of foreign earnings. The three main types of tobacco grown in Zimbabwe are Virginia (flue-cured), Burley (cured) and Oriental. Tobacco accounts for about 12%

of workforce. Tobacco use is significantly prevalent, even among the youth. Total cigarette consumption rose from 1billion in 1995 to 1.05 billion in 1997. The prevalence of tobacco smoking ranges from 19% to 35% and males smoke more than twice as much as women and the smoking rates increase with age. According to a study amongst young people done in Harare, prevalence was 16% among children under 14 years, 21% among 15 – 16 year olds, 28% among 17 – 20 year olds and 33% among over 20 years olds.

Rules & regulations for tobacco control are mainly for protection and promotion of the growing of tobacco. However, the Children's Protection & Adoption Act [Chapter 5:06 of the Statute Law of Zimbabwe] prohibits the sale of liquor, tobacco and drugs to children (below age 18). There has been a health policy since October 1995 for the control of tobacco, which includes a health clause that reads "Smoking may be hazardous to your health". This warning clause and in addition tar & nicotine levels in cigarettes are displayed on every cigarettes packet. Smoking was banned in hospitals & health clinics in 1992, and theatres, cinemas, supermarkets and all pharmacy outlets do not allow smoking on their premises. All local Zimbabwean flights do not allow smoking during flying. Some of the local bus companies (e.g. ZUPCO) forbid smoking on their buses.

Additionally, Zimbabwe commemorates World-No-Tobacco Day and there are regular radio & television educational talks, to sensitise people on the effects of tobacco smoking. The Ministry of Health & Child Welfare has launched awareness campaigns to the public, school education groups, youths- in & out of school, pregnant women. There are however, some disparities in the dissemination of information on the dangers of tobacco as well as gaps in information and behaviour change.